

MEDICINE TODAY

This department of California and Western Medicine presents editorial comment by contributing members on items of medical progress, science and practice, and on topics from recent medical books or journals. An invitation is extended to every member of the California, Nevada and Utah Medical Associations to submit brief editorial discussions suitable for publication in this department. No presentation should be over five hundred words in length.

Bladder Neck Contracture.—The symptoms commonly associated with prostatic hypertrophy, namely, difficult urination, slow stream, frequency, urgency, and dysuria, may occur when the size of the prostate is normal, or even smaller than normal. This phenomenon of "prostatism sans prostate" is due to a fibrous contracture of the bladder neck, affecting mostly its posterior portion, which is elevated above the trigone and forms a dam or "median bar," which obstructs the outflow of urine.

The average age of patients with this condition is less than that of those with adenomatous prostatic hypertrophy. In fact it may be present at birth, and the most common age for its occurrence is from thirty-five to fifty-five. Long continued chronic infection of the prostate or bladder predisposes to bladder neck contracture. Its occurrence is not uncommon, being the cause of the symptoms in 15 per cent of cases of prostatism.

When a patient complains of the symptoms of bladder neck obstruction, and the prostate is normal by rectal palpation, a bladder neck contracture is suspected. A positive diagnosis, however, can be made only by the use of the cystoscope. With this instrument it is found that the bladder neck is more rigid than normal; it is thickened when palpated between the cystoscope and the examining finger in the rectum; and its posterior portion is seen to be elevated above the trigone, forming a bar at the bladder neck. A careful examination is necessary to differentiate it from the neurogenic bladder, from middle lobe prostatic hypertrophy, and from prostatitis without bladder neck contracture.

If a true bladder neck contracture or median bar is present, palliative treatment such as bladder irrigations, sounds, and prostatic massage will sometimes give some temporary relief, but this treatment is usually unsatisfactory and will never cure the condition. It is necessary to eliminate the obstruction at the bladder neck by excising or punching out the median bar. This may be done satisfactorily in most cases through the urethra. There are several types of instruments designed for this purpose, the most important ones of which are the Collings electrome, and the Young punch with its numerous improvements. The utmost familiarity with the use of cystoscopes is an essential prerequisite to the use of these instruments, but when they are used skillfully on patients who have been correctly diagnosed, the results are satisfactory.

It may therefore be stated that bladder neck contracture or median bar causes symptoms similar to those of prostatic hypertrophy, but usually

it occurs earlier and is more often preceded by a chronic infection in the prostate or bladder; that the condition is diagnosed with the aid of the cystoscope; and that most patients can be successfully treated by excising or punching the bladder neck posteriorly with an instrument used through the urethra.

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Transitional Forms of the *Spirocheta Pallida*.—Many investigators have been intrigued with the idea that the typical classical *spirocheta pallida* is but one stage in the cycle of development of the causative organism of syphilis. There are clinical problems in syphilis which are difficult of explanation if we admit only the existence of the full-grown spirochete but which would be more understandable if the existence of smaller types of the organism could be demonstrated. For example, take the theory of conceptional transmission of syphilis. Some authorities have claimed to have observed syphilitic children born of nonsyphilitic mothers. Such an occurrence could be explained only by the spirochete being carried into the ovum in the head of the spermatozoa. Inasmuch as the mature form of the spirochete is larger than the spermatozoa this would seem impossible. If an ultramicroscopic or a finely granular stage of the spirochete could be proved, the possibility of the paternal transmission of syphilis would seem to be established. Saleeby and Greenbaum¹ were unable to find any *spirocheta pallida* in human tissue emulsions which produced syphilis in inoculated animals. At times, the *spirocheta pallida* cannot be demonstrated in the brains of known paretics.

All of the above mentioned problems could be easily solved if we could accept the idea of there being smaller forms, granular forms or ultramicroscopic forms of the spirochete. McDonagh,² Manouelian,³ and Levaditi⁴ have described various granular forms and life cycles of this organism.

Some recent work by Warthin and his co-workers^{5, 6} would seem to furnish almost indis-

¹ Saleeby, E., and Greenbaum, S. S.: Comparative Biologic and Histologic Study of Lymph Glands From Syphilitic Patients. *J. A. M. A.*, Vol. 96, No. 2, page 98, January 10, 1931.

² McDonagh, J. E. R.: The Biology and Treatment of Venereal Diseases. Lea and Febiger, Philadelphia and New York, 1916.

³ Manouelian, Y.: *Compt. rend. de Soc. de Biol.*, 104:249, 1930.

⁴ Levaditi, C.: *Ibid.*, 104:477, 1930.

⁵ Warthin, A. S., and Olsen, R. E.: The Granular Transformation of *Spirocheta Pallida* in Aortic Focal Lesions. *Am. J. Syph.*, Vol. 14, No. 4, page 433, October 1930.

⁶ Warthin, A. S., and Olsen, R. E.: The Apparent Sequence of Spirochete and Granular Forms in Syphilitic Buboos. *Am. J. Syph.*, Vol. 15, No. 2, page 145, April 1931.